DEPARTMENT OF THE ARMY
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND
1216 STANLEY ROAD, SUITE 25
FORT SAM HOUSTON, TEXAS 78234-6010

REPLY TO ATTENTION OF

MCHS-IS

23 June 2003

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Minutes of the US Army Medical Command Data Quality for AMEDD Success Team (DQFAST)

1. The DQFAST met in Room 107, US Army Patient Administration Systems and Biostatistics Activity (PASBA) Conference Room, Building 126, at 0900 on 15 May 2003.

a. Members Present:

LTC Shero, MEDCOM, HP&S
MAJ Wesloh, Deputy Director, PASBA
MAJ Ulsher, Decision Support Branch, PASBA
MAJ Briggs-Anthony, Data Management Branch, PASBA
Ms. Robinson, Data Quality Section, PASBA
Mr. Padilla, RM, MEDCOM
Mr. Cardenas, AMPO, MEDCOM
Ms. Mallett, PASBA

b. Members Absent:

COL Clark, Team Leader, PASBA
COL Jones, ACofS, HP&S, MEDCOM
LTC Young-McCaughan, Outcomes Management, MEDCOM
MAJ Stewart, PAD, MEDCOM
MAJ Petray, RM, MEDCOM
MAJ Anderson, IMD, OTSG
CPT Blocker, Decision Support Cell, OTSG
Ms. Cyr, ACofS, PA&E, MEDCOM
Ms. Tremont, OTSG
Mr. Beers, Internal Review, MEDCOM
Mr. Fannin, IRAC, MEDCOM
Ms. Bowman, TRICARE Operations Division, MEDCOM
Ms. Bacon, AMPO, MEDCOM
Mr. James, Data Analysis Section, PASBA
Mr. Bacon, Data Quality Section, PASBA

2. Opening Remarks. None.

3. Old/Ongoing Business.

a. Approval of Minutes. The April minutes were approved as written.

b. The DQFAST Metrics (exceptions only). There are three metrics for discussion.

(1) Standard Inpatient Data Record (SIDR) Metric. On the SIDR metric, Fort Eustis dropped to 96 percent. They had 1 record out of 26 that did not make it into the SIDR. They have such a low volume of records that 1 record will change them from green to red.

(2) Standard Ambulatory Data Record (SADR) Providers Specialty Metric. Fort Monmouth has been in the red and is currently at 59 percent. Fort Monmouth did not have their provider specialty code listed in Composite Health Care System (CHCS). In the SADR there was combat related data that was blank. They are correcting this and we should see an improvement next month.

(3) SADR Timeliness Metric. The SADR Timeliness Metric has a lot more red: Fort Bliss has a backlog in coding that they are working on. Fort Belvoir has a problem that is presently being researched. West Point has a backlog in coding from the Emergency Room (ER). They had one coder working and they are considering having the ER providers' respective departments help with the backlog. Tripler Army Medical Center (TAMC) was not allowing their providers to do any coding and as a result they had a huge backlog built up since the change in their methodology. Providers are now doing some of the coding and TAMC has improved from last month's 52 percent to 85 percent this month. We do not know the problem with Seoul and have not been able to contact them. We have no information on Eisenhower AMC problem. Fort Campbell had a coding backlog due to heavy deployment which effected their medical treatment facility (MTF). They also had some transmittal problems but were not able to confirm the problem. Fort Rucker has a backlog in coding and also have a new Administrator at their facility. We determined they were not properly extracting their records for transmission.

c. Data Quality Management Control (DQMC) Program.

(1) DQMC Program New Issues. None.

(2) DQMC Program Update, enclosure 1.

(a) On 12 May PASBA briefed Major General Farmer on the DQMC Program. The Medical Expense and Performance Reporting System (MEPRS) is still catching up from their software problem, but are showing consistent improvement. The coding arena compliance remains about the same; Evaluation and Management (E&M) is at 82 percent compliance, International Classification of Diseases is 79 percent compliance, and Current Procedural Terminology (CPT) is at 92 percent compliance.

(b) We received a response from TRICARE Management Activity (TMA) on 2 issues that we forwarded for review. One was removing the MEPRS Early Warning and Control System (MEWACS) questions. Our request was declined. However, they expanded the questions on the review list from 1 to 3, and they modified the question on the commander's statement to be more specific. They also added a guide and an executive summary on the MEWACS website for data quality managers and/or MEPRS personnel who want to review the MEWACS data. The changes to the questions will be in effect beginning FY 04. The end of day proposal was declined. We asked for the end of the day completion to be moved from midnight the day of the appointment until noon the following day. The TMA instead suggested the use of a multiple patient check-in function in CHCS. We do not advocate this and believe this will cause other problems. When the Provider Graphic User Interface (P-GUI) deploys it will force the appointment to be entered in CHCS so the provider can insert the orders for that patient. The TMA DQMC workgroup will meet on 29 June. This will be the first meeting where we will begin reviewing the commander's statement and any changes will be effective in FY 04. Currently, we do not have any big issues for the Army.

(3) Coding Update.

(a) We have established a new process for answering Help Desk questions. Our customers can go to the PASBA website and submit inquiries electronically.

(b) We have gone through the Uniform Biostatistical Utility (UBU) and a number of TMA level re-iterations of the professional services for outpatient coding guidelines. There are still corrections to this document needed. The AMEDD's approach at the next UBU will be to develop a concerns list. The AMEDD's position is to use the coding references already in existence with and develop a document that highlights specific DOD coding guidelines.

(c) There is an AMEDD level issue concerning Speech Pathology and Audiology coding. The TMA has produced guidance that erroneously has effected data quality because they are not correctly annotating codes. Colonel Chandler and Major Ulsher are working together on this and will approach TMA and UBU to correct the inconsistent guidance provided at TMA level.

(d) Another issue is using the 97 versus 95 coding guidelines. The Office of The Surgeon General (OTSG) and TMA are stating the 97 guidelines are the correct ones to use. This statement is not correct. At this time there is no system that requires you must use 97 guidance. This topic will be addressed again in the UBU.

(e) Advanced MED auditing directed by TMA is obviously a topic of concern for the data quality personnel. Six of our sites have been selected for review, but none have been notified. Once they have been notified they will have only 15 days to reply to Advanced MED for the survey. The 6 sites are Fort Riley, Fort Bliss, Fort Eustis, Fort Sill, Fort Sam Houston, and Fort Belvoir. A notification letter is supposed to be sent to the hospital commanders. Our concern is if the letter does not reach the commander or get disseminated to the applicable personnel in a timely manner, it will look like the AMEDD did not comply. For future audits TMA will notify MAJ Ulsher and she will notify the appropriate personnel. Once facilities receive their letter they should start processing the requested data. Advanced MED will not be physically visiting their facility but is sending a letter requesting the information be mailed to them.

(f) Another AMEDD data quality issue concerns the data we have in our repository on laser tattoo removal. There is inconsistency throughout the AMEDD and the other services concerning which codes are to be used. An AMEDD champion for the proper removal of tattoos contacted MAJ Ulsher and they are working to develop some guidelines that are going to go from the AMEDD to the American Medical Association (AMA) with recommendations to pursue the proper coding introduction into the next CPT manual. We are seeking tri- service agreement on the use of unspecified surgical procedure integamantary system code of 17999 in the interim.

(g) In mental health coding there were 238,000 incorrect codes for E&M and CPT. We are not getting proper data out of the system because the codes are being used improperly resulting in up-coding. This can potentially result in fraud. We provided the CPT psychiatry guidelines from the CPT manual to all the sites. We discussed it in the coding video teleconference yesterday. We will bring it up to the UBU as an item of concern to the AMEDD. This is something within the AMEDD we need to correct and this means advising the sites on the proper use of the coding procedures in the manual.

(h) There is no TMA guidance for coding Serious Acute Respiratory Syndrome. The PASBA along with COL Yoder developed some information that was distributed to the coders in our services. This will help to provide some ideas on how to code for the signs and symptoms. The information we provided came from the Center for Disease Controls' website. To our knowledge at this point there have not been any reported cases.

(i) Congressional mandates require that we cannot perform any illegal or elective abortions at MTFs. Yet we are consistently seeing erroneously reported abortion data submitted via the SADR and the SIDR. This use of the wrong codes results in the perception that we are actually conducting elective or illegal abortions when we are not. Education across the services is something that probably needs to be addressed from this committee through MEDCOM and out to the sites. We just went through a review for the congressional report and we received a call from TMA health affairs about the data that we submitted. We need to prepare a plan of action in the AMEDD to ensure that the sites are not coding abortions erroneously.

(j) The PASBA is having on going discussions on post deployment guidance. The PASBA has no problem from an AMEDD position on the pdhealth.mil website for guidance and we are using the post deployment DD-2796 form. The issue is at TMA level. The post deployment guidance indicates that V70.5_ _ 6 code must be used as a secondary listed diagnosis code for all individuals that report to a facility, and are asked and give a positive response to the question; “Do you believe that this problem you or your child is experiencing is related to a deployment of your sponsor?” If they respond yes then the facilities are being instructed to use V70.6_ _ 6 as a diagnosis code. The PASBA’s concern is that per coding conventions published guidance,; you cannot list V70.5 or V70.X in any section of the diagnosis. This is an issue for the MEDCOM and higher headquarters to address. From a coding stand point the issue is that we should not be seeing it in the second list of codes. Through education and feed back we will get the information to TMA so they can make a correction to that before we start seeing thousands of cases. We want the data to indicate that it was post deployment related, as the guidance states at pdhealth.mil. But we want to ensure the code is maintained or indicated in a proper location.

(k) Coding for Smallpox is another problem area for coding data quality. A report in the AMEDD bulletin indicated we had no small pox cases. We do not know how the person that contributed the information to that article could say there have been no small pox cases. When we pulled a SADR report it indicated we erroneously had 102 small pox cases. At PASBA within the past 2 months we have contacted the sites one by one and informed them of this error.

(l) A motion was made to move the DQFAST meetings to a quarterly basis as opposed to a monthly basis, since we do have the data quality management control reporting every single month. **Decision: This motion will be tabled and discussed at the next committee meeting.**

(m) The 3M initiative for training is continuing to flow smoothly. We do have facilities that are not participating even though it is a tool to improve their data quality process internally. They choose not to use it, because no letter from OTSG has been

signed endorsing the product. This is an obstacle that we have tried to overcome with a lot of marketing and communication with MTF's coding personnel. The 3M training is going to expire 31 July 2003 and thousands of people are going to miss the opportunity to use it.

d. MEPRS Expense Update.

(1) A memorandum from MEDCOM DCSRM will allow the providers to redirect some of their administrative time away from patient care coding; therefore, we will get a clearer picture of the actual available provider time for patient care.

(2) We sent PASBA the financial reconciliation and site transmission reports to auto fill future DQMC Program Commander's Statements.

(3) The Expense Assignment System, version IV (EAS IV) web base training is about to be released to everyone so they can start using it. We have a demonstration with MEDCOM DCSRM 15 May and it should be available on the web by the middle of June, right after the Resource Management Conference. This will assist many individuals in learning how to code into EASIV and how to process data in EAS IV. We should see some improvement once this online training is available. Mr. Harold Cardenas will be one of the system administrators that will be setting up accounts as requests come in.

e. Deployment Issues.

(1) The 86th CSH was initially in Kuwait, but then deployed to Iraq. We did not have any communication with them the entire time they were in Iraq. They saw about 550 patients and they are getting ready to redeploy. MAJ Briggs-Anthony is in the process of assisting them expedite getting the records prepared prior to them redeploying by getting the copies of the SIDRS and all the information that we need for Patient Accounting and Reporting Realtime System (PARRTS).

(2) The 28TH CSH is no longer operating as split operations. They have consolidated and we have received very little of information from them. We have not received any SIDRS, but we have received some PARRTS information. The 47TH CSH is apparently very far down range and no one has heard from them. The 21st CSH is the only unit that actually has the AQCESS database from the PAD deployment CD. They can input all their data and send the file to PASBA and PASBA uploads that information into PARRTS. The PASBA has had a successful transmission with the 21ST CSH.

4. New Business. None

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5. The meeting adjourned at 0945. The next meeting will be on 24 June 2003.

/s/
LARRY J. CLARK
COL, MS
DQFAST Team Leader

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1-Each Committee Member